

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16482

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1. DECEASED-NAME (Type or print)	First JOHN	Middle ARTHUR	Last BISCOE	2a. DATE OF DEATH NOVEMBER 13, Day 1968 Month Year	2b. HOUR M	
3. SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH JULY 5, 1887		6. AGE (In years last birthday) 81	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign, country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ST. MARY'S		
10. CITY OR TOWN OF DEATH LEONARDTOWN, 76 18 1	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMING, WATERMAN		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN PINEY POINT	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
14. FATHER'S NAME WILLIAM	Middle BISCOE	15. MOTHER'S MAIDEN NAME SARAH		Middle 7	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-16-2062 A	17. INFORMANT HOLTON R. BISCOE PINEY POINT, MARYLAND Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4442 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Thrombosis of Mesenteric Artery days						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs day days						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5702						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on Nov. 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE JAMES P. JARBOE	DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 11/15/68			
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS JAMES P. JARBOE M. D.		22f. ADDRESS GREAT MILLS, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Nov. 16, 1968	23c. NAME OF CEMETERY OR CREMATORIUM ST. MARKS		23d. LOCATION (City or Town) VALLEY LEE, ST. MARY'S, MARYLAND	(County) (State)	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY	ADDRESS LEONARDTOWN, MARYLAND		25a. RECD BY REGISTRAR Charles J. George	25b. REGISTRAR'S SIGNATURE Charles J. George	DATE NOV 19 1968	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, then 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M. Page 5 may be retained for your files.

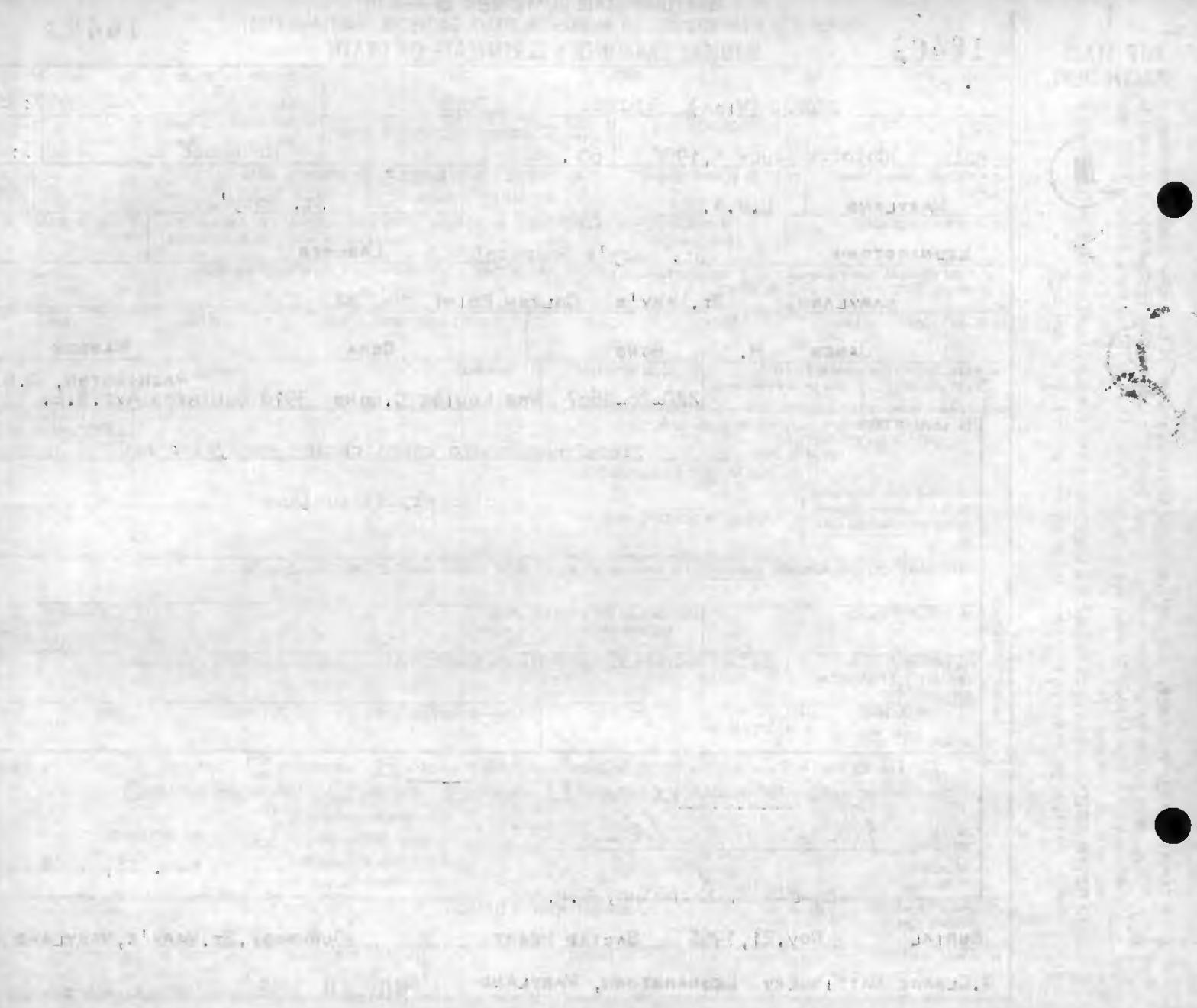
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16469

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16483

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
		THOMAS (VICK) VICTOR BOND			<input checked="" type="checkbox"/>	11	16	1968	7:05 p
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS				
Male	Colored	JULY 5, 1908	60 ? yrs.	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	NEVER MARRIED	<input checked="" type="checkbox"/>	9. COUNTY OF DEATH		2d. HOUR
MARYLAND		U.S.A.		WIDOWED	DIVORCED	<input type="checkbox"/>	St. Mary's		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
LEONARDTOWN		St. Mary's Hospital			LABORED				
13a. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
MARYLAND		ST. MARY'S		COLTON POINT					
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost	
		JAMES	H.	BOND	CORA				MADDOX
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT		ADDRESS		
		220-26-2667			MRS LOUISE C. BOND		WASHINGTON, D.C. 3910 SOUTHERN AVE. S.E.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bronchopneumonia complicating emphysema and							
485X		DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		pulmonary fibrosis							
(b)		DUE TO, OR AS A CONSEQUENCE OF							
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
491X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Ronald N. Kornblum		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		Nov. 18, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)	(State)
BURIAL		Nov. 21, 1968		SACTED HEART		BUSHWOOD, ST. MARY'S, MARYLAND			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. CLARKE MATTINGLEY		LEONARDTOWN, MARYLAND				NOV 20 1968 <i>W. Clarke Young</i>			



FOR STATE
HEALTH DEPT.

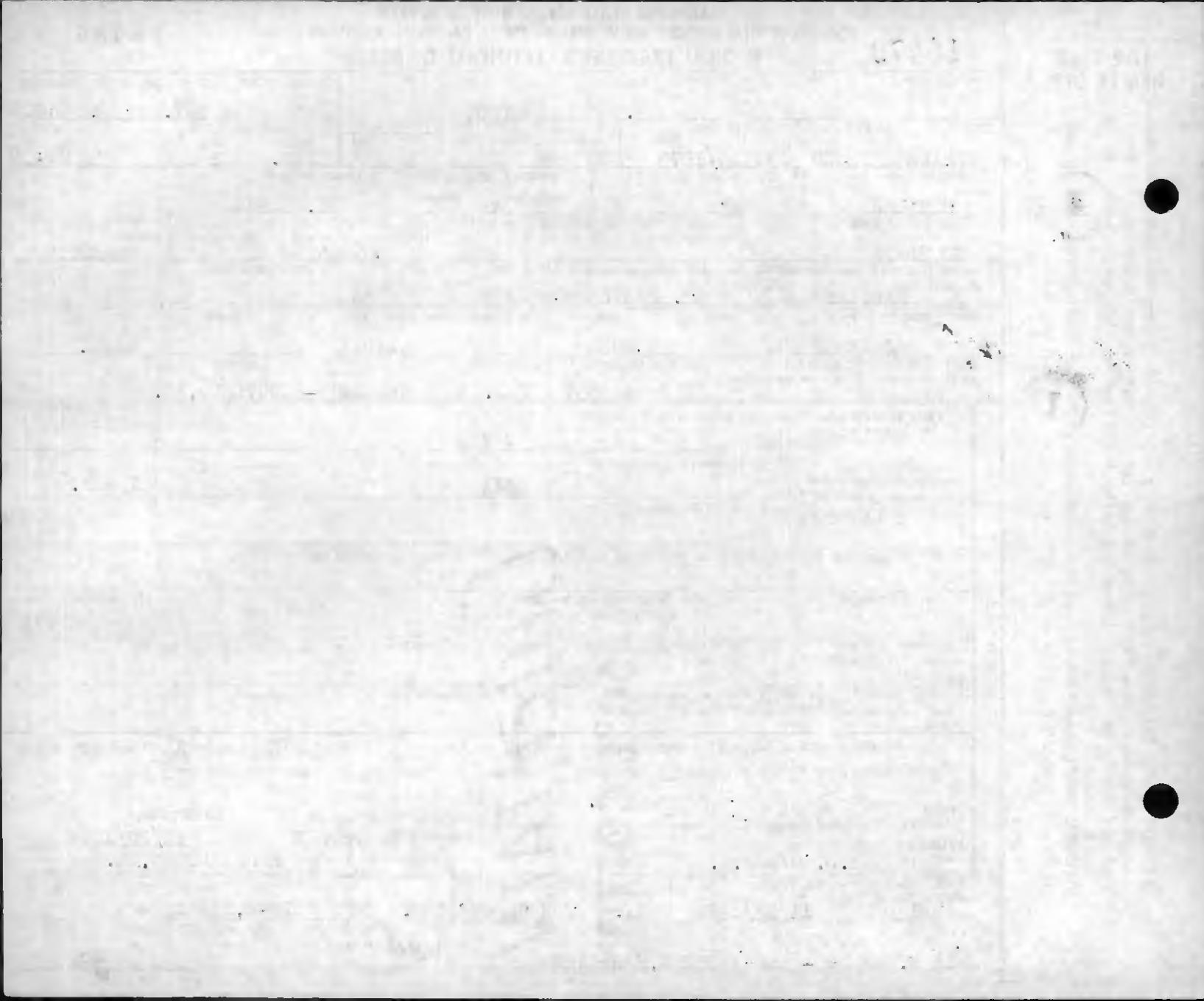
3
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED				Month Day Year	2b. HOUR			
ROSA			B.	BRYAN		<input type="checkbox"/>				NOV. 19 1968	9:00AM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.									
FEMALE	NEGRO	12/26/1879	88 YRS.	MONTHS	DAYS	HOURS	MIN							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD				2d. HOUR		
MARYLAND		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		ST. MARYS		Manth NOV. Day 19 Year 1968				10:30		
10. CITY OR TOWN OF DEATH SCOTLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC					
MARYLAND			13b. COUNTY	ST. MARYS	SCOTLAND	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER					
14. FATHER'S NAME JAMES HENRY			15. MOTHER'S MAIDEN NAME BARNES			LAURA			Middle			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. NO 212 16 6357			17. INFORMANT MRS. ROSA HEWLETT - SCOTLAND, MD.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369			DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			C V A						IMMED.		
(b)			DUE TO, OR AS A CONSEQUENCE OF			XXX								
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION 3371X			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
19c. MEDICAL CERTIFICATION									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>W.M.D. Boyd</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 11/20/1968					
EXAMINER'S NAME (Type) WM.D. BOYD M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county) LEONARDTOWN, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/23/1968		23c. NAME OF CEMETERY OR CREMATDRY ST. PETER CLAVER CEM.			23d. LOCATION (City or Town) RIDGE, MARYLAND		(County)		(State)			
24. FUNERAL DIRECTOR <i>John M. Welch</i> JOHN M. WELCH - LEONARDTOWN, MARYLAND		ADDRESS			25a. REC'D BY REGISTRAR NOV. 22 1968		25b. REGISTRAR'S SIGNATURE <i>John M. Welch, Judge</i>							



FOR STATE
HEALTH DEPT.

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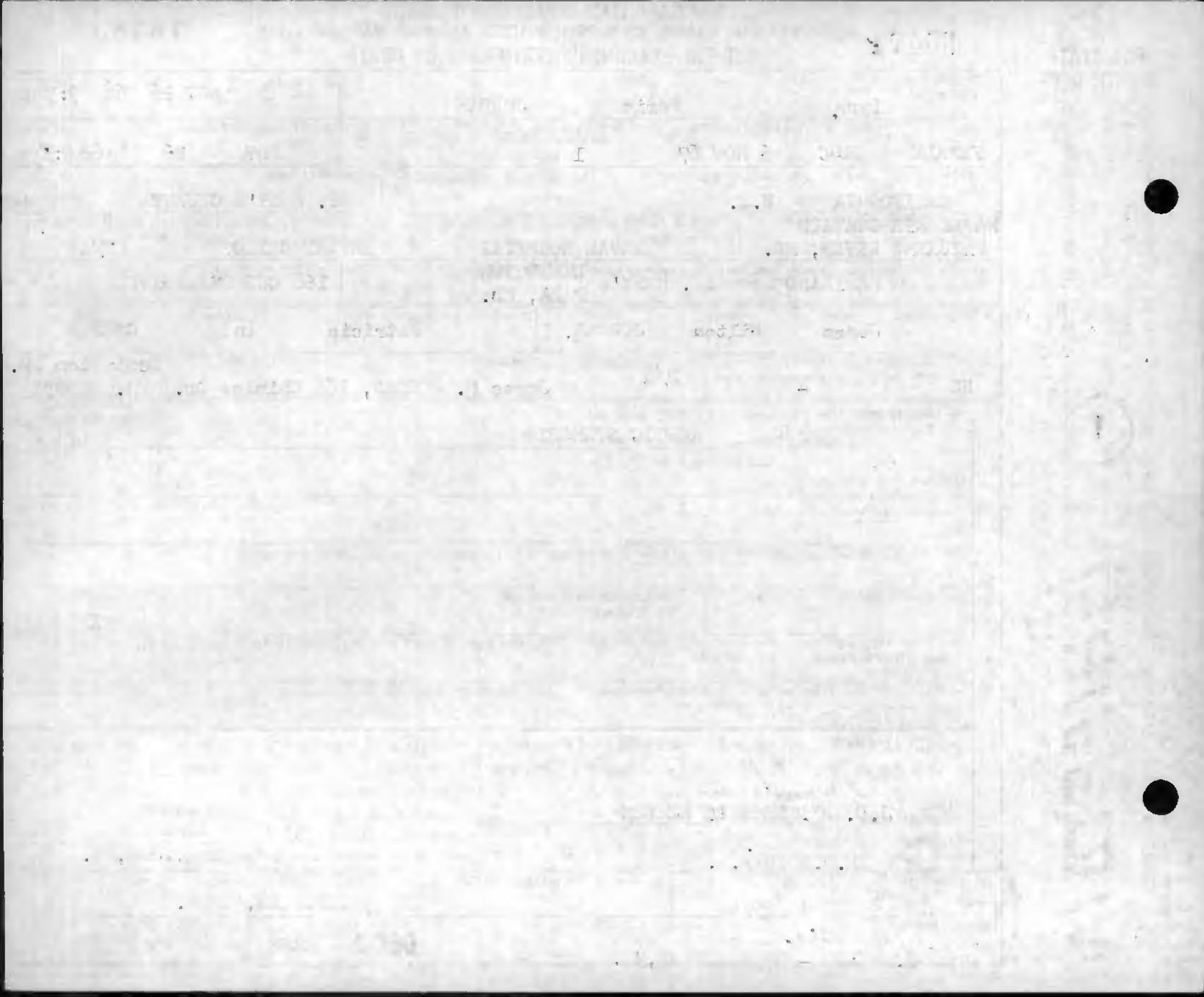
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16485

1. DECEASED NAME (Type or Print)	First Lynn	Middle Marie	Last JORDAN	2a. DATE KNOWN OF DEATH ESTIMATED MATED	Month NOV 26	Day 68 19	Year 9:30 PM M	2b. HOUR 9:30 PM
3. SEX FEMALE	4. RACE CAUC	5. DATE OF BIRTH 6 NOV 67	6. AGE (in years last birthday) 1 YRS.	IF UNDER 1 YEAR MONTHS 1	IF UNDER 24 HRS DAYS 0	AMIN. 0		
7a. BIRTHPLACE (State or foreign country) CALIFORNIA	7b. CITIZEN OF WHAT COUNTRY? U.S.	B. MARRIED WIDOWED DIVORCED	C. NEVER MARRIED X	9. COUNTY OF DEATH ST. MARY'S COUNTY	2c. DATE PRONOUNCED DEAD Month NOV Day 26 Year 1968 9:30 PM			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL AIR STATION PATUXENT RIVER, MD.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) INFANT CHILD		12b. KIND OF BUSINESS OR INDUSTRY N/A				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MARYLAND		13b. COUNTY ST. MARY'S PARK, MD.		13d. INSIDE CITY LIMITS? YES X NO	13e. STREET AND NUMBER 168 CHINLEE DRIVE			
14. FATHER'S NAME James	Middle Milton	Last JORDAN	15. MOTHER'S MAIDEN NAME Patricia	16. SOCIAL SECURITY NO. N/A	17. INFORMANT James M. JORDAN, 168 Chinlee Dr. Md. 20653	ADDRESS Lexington Pk.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3959 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4211								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES X NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> J.D. Anderson								
ACTUAL SIGNATURE J.D. ANDERSON LT MC USN		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 11/28/68		
EXAMINER'S NAME (Type) WM.D. BOYD M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) LEONARDTOWN, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT	23b. DATE 11/29/68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City or Town) LANSDALE, PENNA.	(County) (State)		
24. FUNERAL DIRECTOR John M. Welch	ADDRESS JOHN M. WELCH - LEONARDTOWN, MD.			25a. REC'D BY REGISTRAR DATE DEC 3 1968	25b. REGISTRAR'S SIGNATURE James J. Welch			



FOR STATE
HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

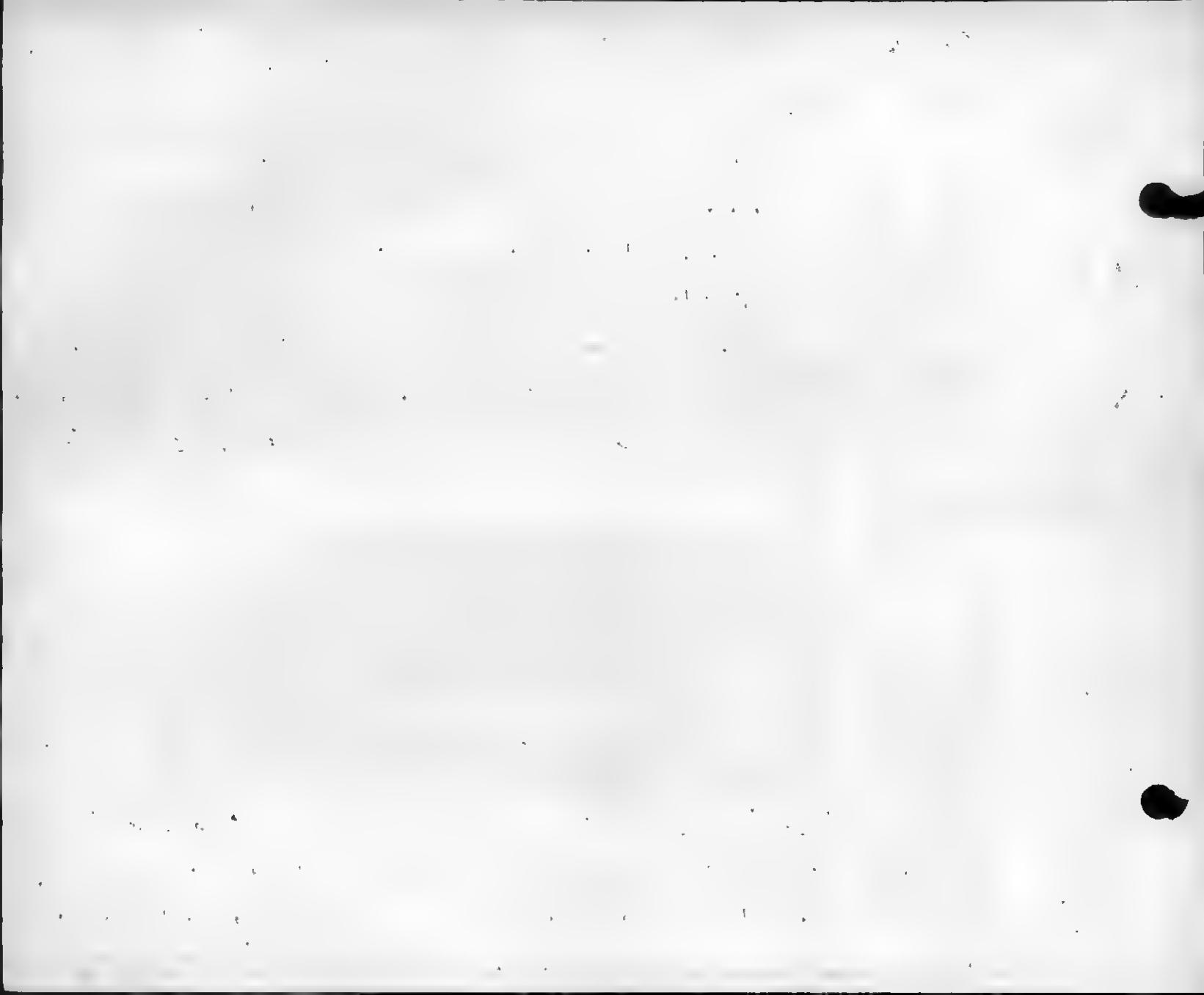
16472 16486

1. DECEASED-NAME (Type or Print)		First William	Middle Oliver	Lost KEAVENY	20. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> NOV 23	Month NOV	Day 23	Year 168	2b. HOUR 10:21
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH OCT 7, 1937	6. AGE (In years last birthday) 31 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 00	MIN 00		2d. HOUR 10:21
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH St. Mary's			
10. CITY OR TOWN OF DEATH Patuxent River		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) AV ANTISUBWARTECH		12b. KIND OF BUSINESS OR INDUSTRY U.S.Navy			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY St. Mary's		13c. CITY OR TOWN PAXRIV		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER NAS PAXRIVMD 20670	
14. FATHER'S NAME Andrew		First (NMN)	Middle KEAVENY	Lost	15. MOTHER'S MAIDEN NAME Nora		First (NMN)	Middle COSTELIO	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. AUG62-NOV68		17. INFORMANT Official U. S. Navy Records		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1Hr 11Min	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Depressed Skull Fracture with Puncture</u> 819.9</p> <p>DOUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>(b) <u>Auto Accident</u> DOUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>1054</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 10:21P.M. NOV 23 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Auto Accident					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Road		21f. LOCATION Street or R.F.D. No. Willows Road Lexington Park St. Mary's Md.		City or Town County State			
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Wm. D. BOYD M.D.</p>									
ACTUAL SIGNATURE I. I. MASON, LT MC USNR		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.		22b. DATE SIGNED 23 NOV 68			
EXAMINER'S NAME (Type) I. I. MASON		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.		ADDRESS (Street, city, town, or county) MEMPHIS, TENN.					
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b. DATE 11/26/1968		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) MEMPHIS, TENN.		(County) (State)	
24. FUNERAL DIRECTOR John M. Welch		ADDRESS JOHN M. WELCH - LEONARDTOWN, MD.		25a. REC'D BY REGISTRAR DATE DEC 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First FRANK	Middle MATTINGLY	Last KNIGHT	2a DATE OF DEATH Month NOVEMBER	Day 24	Year 1968	2b. HOUR M
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MAY 12, 1900	6 AGE (in years last birthday) 68		7 IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ST. MARY'S			
10 CITY OR TOWN OF DEATH LEONARDTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MATE		12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN MECHANICSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER		
14. FATHER'S NAME First BANJAMIN		Middle CARROLL	Last KNIGHT	15. MOTHER'S MAIDEN NAME First LIZA		Middle NOEMA	Last MATTINGLY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT JOSEPHINE W. KNIGHT		Address MECHANICSVILLE, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4009		DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost.		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hr		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. MECHANICSVILLE	City or Town MECHANICSVILLE	County MD.	State	
22a. I certify that (I) (this hospital) attended the deceased from Nov 24, 1968 to Nov 24, 1968 , that (I) we last saw the deceased alive on Nov 24, 1968 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE J. Roy Guyther		22c. DATE SIGNED 26 Nov 68						
22d. PHYSICIAN'S NAME (Type) J. Roy GUYther M. D.		22e. ADDRESS MECHANICSVILLE, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/27/68		23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHNS		23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, ST. MARY'S, MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MD.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

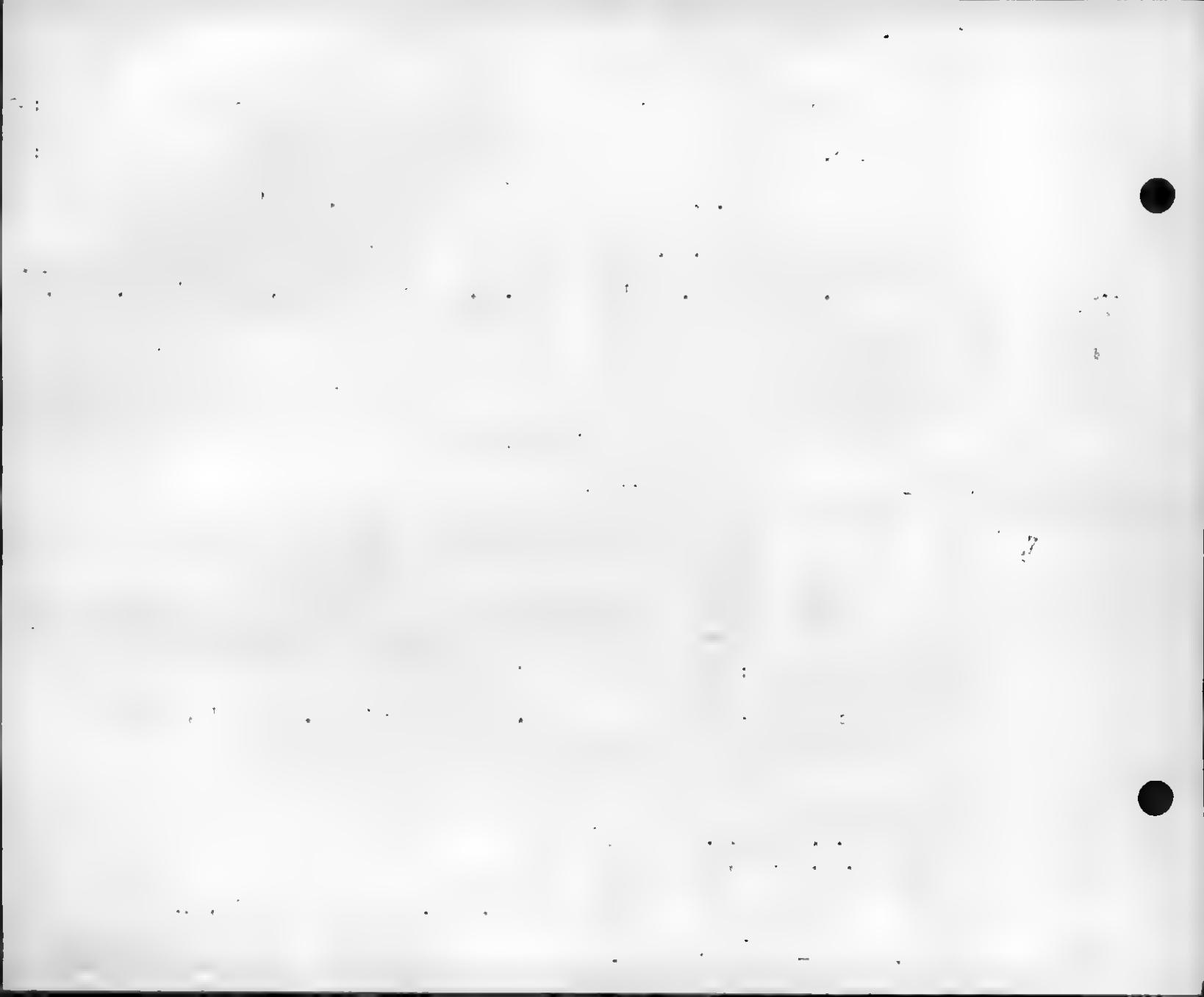
1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M. 3 Page 5 may be retained for your files.

2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Death Department, and 3 with the State Death Department of Health.

3
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First Lucille	Middle Ann	Last KNIPSTEIN	2a DATE KNOWN OF DEATH ESTIMATED MATED	Month NOV	Day 24	Year 1968	2b HOUR 00:30	
3 SEX Female	4 RACE Cauc.	5 DATE OF BIRTH 8/20/1927	6 AGE (in years last birthday) 41 yrs	F JNDER 1 YEAR MONTHS DAYS	H JNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month NOV				2d HOUR 00:30
7a BIRTHPLACE (State or foreign country) RHODE ISLAND		7b CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH St. Mary's				Md.	
10 CITY OR TOWN OF DEATH Patuxent River		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U. S. Naval Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife				12b KIND OF BUSINESS OR INDUSTRY Housewife	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY St. Mary's	13c CITY OR TOWN Calif. Md.	13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER Lot #4, Old Rolling Rd. Calif.	Md.				
14 FATHER'S NAME THOMAS		Middle GORMAN	Last	15 MOTHER'S MAIDEN NAME DOROTHY	First	Middle	Last	KEENAN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO.		17 INFORMANT RALPH KNIPSTEIN - SAME AS #13	ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries Multiple, Extreme</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <u>Auto Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?					
21a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR <input type="checkbox"/> 11:30 P.M. NOV 23 1968			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Auto Accident					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) Street			21f. LOCATION Street or R.F.D. No. (City or Town) County State RT. 235 California Md., St. Mary's, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town or county)			22b DATE SIGNED 24 NOV 68					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 11/27/1968	23c NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATL. CEM.			23d LOCATION (City or Town) ARLINGTON, VA.		(County) (State)		
24 FUNERAL DIRECTOR John M. Welch		ADDRESS JOHN M. WELCH - LEONARDTOWN, MD.			25a. REC'D BY REGISTRAR DATE DEC 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certifcate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages head 2 with Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16475

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1042.

1 DECEASED NAME (Type or Print)		First	M date	LAST	2d DATE KNOWN OF EST. DEATH MATED	Month	Day	Year	2b HOUR	
Ralph		Frank	KNIPSTEIN	SR.	NOV 24	168	00:30			
3 SEX Male	4 RACE Cauc.	5 DATE OF BIRTH FEB 7, 1924	6 AGE (in years 1st birthday) 44	7f UNDER 1 YEAR MONTHS YRS	7f UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month NOV Doy 24 Year 1968 00:30				
7b BIRTHPLACE (State or foreign country) Indiana		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH St. Mary's				2d HOUR	
10 CITY OR TOWN OF DEATH Patuxent River		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U. S. Naval Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Aviation Machinist			12b KIND OF BUSINESS OR INDUSTRY U.S.Navy		
13a USUAL RESIDENCE (Where deceased resided, if institution before admission) STATE Md.		13c CITY OR TOWN St. Mary's Calif. Md.		13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER Lot #4, Old Rolling Rd. Calif.			Md.		
14 FATHER'S NAME (DECEASED) Edwin Fred KNIPSTEIN SR.		15. MOTHER'S MAIDEN NAME Viola Sofi MILLER								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO MAR 41-NOV 68 312-18-8967		17 INFORMANT Official U. S. Navy Records	ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decapitation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a), stating the <u>underlying cause</u> Auto Accident (b) Auto Accident DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>11:30 A.M.</i>										
19a DATE OF OPERATION <i>11/24</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 11:30 M. NOV 23 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Auto Accident						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION Street or R.F.D. No City or Town County State Rt. 235 California Md., St. Mary's, Maryland						
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>J. D. Mason, M. D. Boyd</i>		EXAMINER'S NAME (Type) J. D. MASON, LT MC USNR		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 24 NOV 68
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 11/27/1968		23c NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATL. CEM.		23d LOCATION (City or Town) ARLINGTON, VA.		(County) (State)		
24 FUNERAL DIRECTOR John M. Welch		ADDRESS JOHN M. WELCH - LEONARDTOWN, MD.		25a REC'D BY REGISTRAR DEC 2 1968		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10. **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed by a physician or attending physician.

11. **LOG:** Log 4 may be retained by the hospital or attending physician.
12. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Log 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) JESSIE CORNELIUS LAWRENCE			2a. DATE OF DEATH Month NOVEMBER 30 1968	2b. HOUR Year IF UNDER 1 YEAR MONTHS DAYS HOURS MIN M
3. SEX MALE		4 RACE NEGRO	5. DATE OF BIRTH NOVEMBER 11, 1903	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH ST. MARY'S		10 CITY OR TOWN OF DEATH LEONARDTOWN		
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		12b. KIND OF BUSINESS OR INDUSTRY Md.
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. CITY OR TOWN ST. MARY'S	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER VALLEY LEE
14. FATHER'S NAME JOHN FRANCIS LAWRENCE		15. MOTHER'S MAIDEN NAME MAGGIE WHALEN	Address VALLEY LEE, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Y		16b. SOCIAL SECURITY NO. 577-16-6290	17. INFORMANT K ALVERTA LAWRENCE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hepatitis Encephalitis		IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Per for Gall Bladder & Metastasis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 6-12 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 151				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) at work		21b. TIME OF INJURY HOUR A.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) At home, Farm, Street, Factory, Office Building, etc	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, Farm, Street, Factory, Office Building, etc)	21f. LOCATION Street or R.F.D. No LEXINGTON PARK, MD.	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 2 Nov 1968 to 30 Nov 1968 , that (I) (we) lost saw the deceased alive on 2 Nov 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.				
22b. SIGNATURE Ernest L. Rehm, M.D.		ATTENDING DEGREE PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 2 Dec '68	
22d. PHYSICIAN'S NAME (Type) ERNEST L. REHM, M.D.		22e. ADDRESS LEXINGTON PARK, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE DEC. 3, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ST. MARKS	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MD.		25a. REC'D BY REGISTRAR DEC 5 1968
				25b. REGISTRAR'S SIGNATURE <i>please judge</i>



FOR STATE
HEALTH DEPT.

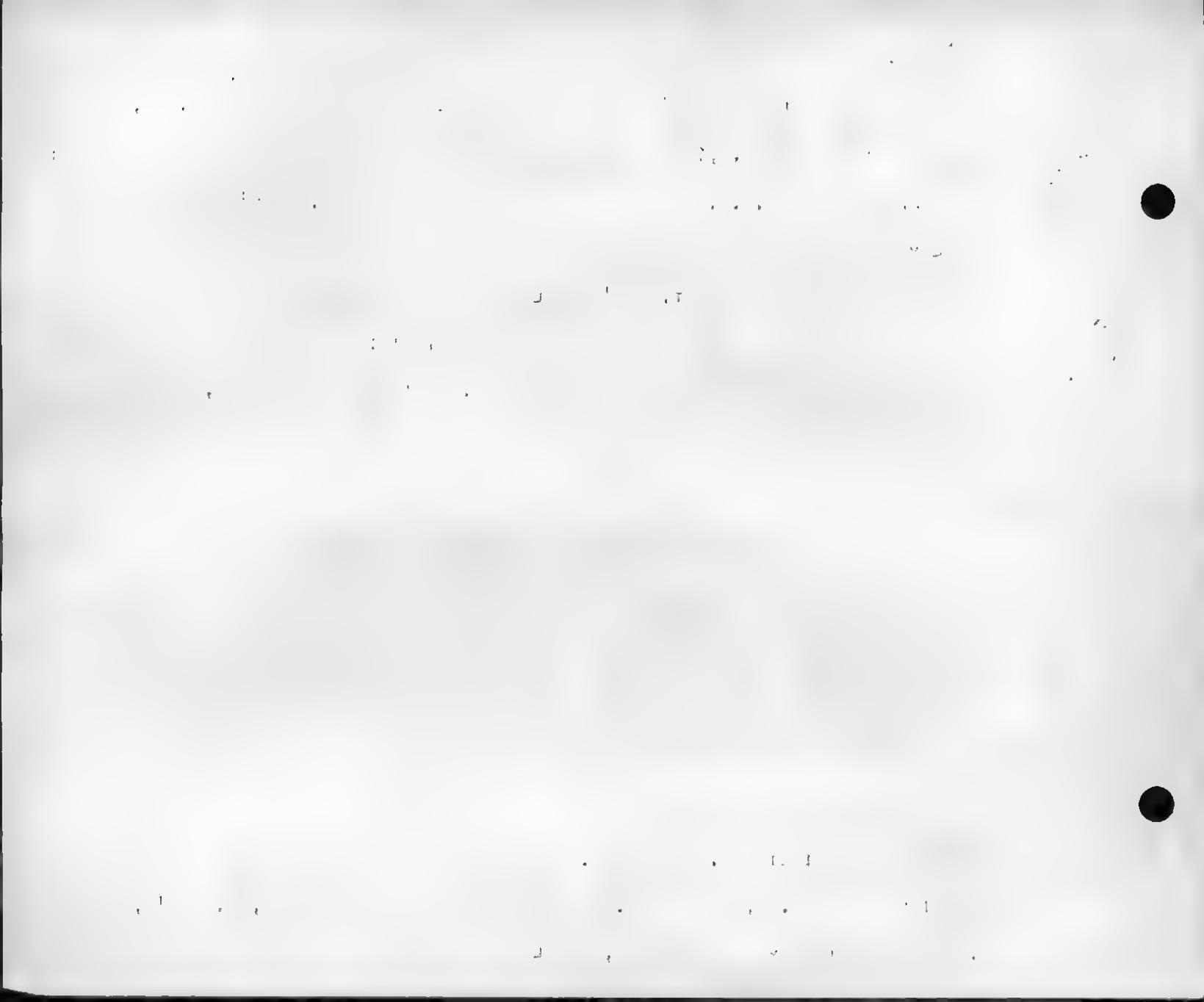
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 17. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First ELLEN	Middle IVY	Last MATTINGLEY	2a DATE KNOWN OF DEATH ESTI- MATED	Month Nov. 20,	Day 19	Year 68	2b HOUR AM		
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month NOVEMBER				2d HOUR 12:30 M	
FEMALE	WHITE	AUG. 1, 1875	93 YRS			Day	20, 1968	19			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ST. MARY'S						
10. CITY OR TOWN OF DEATH HOLLYWOOD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AT HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY ST. MARY'S	13c. CITY OR TOWN HOLLYWOOD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER						
14. FATHER'S NAME LEO		Middle GREENWELL	Last	15. MOTHER'S MAIDEN NAME VIRGINIA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT			ADDRESS					
			LUKE G. MATTINGLEY			HOLLYWOOD, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. i9 FRACTURED HIPS 7 wks											
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 10-3-68											
19a. DATE OF OPERATION 10-3-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? FRACTURED HIPS			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR AM 7:00 P.M. OCT 1, 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) auto accident							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) ROUTE 574		21f. LOCATION Street or R.F.D. No. Hollywood			City or Town	County	State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>William D. Boyd, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 11-20-68			
EXAMINER'S NAME (Type) WILLIAM D. BOYD M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) HOLLYWOOD, ST. MARY'S, MARYLAND						
23a. BURIAL, CREMATION BURIAL		23b. DATE Nov. 22, 1968		23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHNS CEMETERY			23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, ST. MARY'S, MARYLAND				
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND			25a. REC'D BY REGISTRAR DA NOV 22 1968			25b. REGISTRAR'S SIGNATURE <i>W. Clarke Mattingley</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16478

16478

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 0000M	
Desirea Renee MOCNEY					11	11	88	11 11	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH NOV 10, 1968		6. AGE (In years from birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ST. MARY'S		12b. KIND OF BUSINESS OR INDUSTRY NA	
10. DEATH STATION PATUXENT RIVER, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Newborn Child		12b. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Newborn Child		12c. KIND OF BUSINESS OR INDUSTRY NA	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN AIR		13d. STREET AND NUMBER 763B NEMO NAS PAX RIV.		13e. STREET AND NUMBER 763B NEMO NAS PAX RIV.	
14. FATHER'S NAME Steven Leroy MOCNEY		15. MOTHER'S MAIDEN NAME Sharon Marie PIERSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NA		16b. SOCIAL SECURITY NO. NA		17. INFORMANT Official U.S. Navy Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		STAPHYLOCOCCAL SEPSIS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Birth to Death was 16 hours 17 minute	
406X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA-ASPIRATION							
		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 10 NOV, 19 68, to 11 NOV, 19 68, that (I) (we) last saw the deceased alive on 11 NOV 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE D. C. PIETRONTO M.D. MC USIR		22c. DATE SIGNED 11-11-68							
22d. PHYSICIAN'S NAME (Type) D. C. PIETRONTO M.D.		22e. ADDRESS NAVAL HOSPITAL PATUXENT RIVER, MD. 20670							
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b. DATE 11-13-68		23c. NAME OF CEMETERY OR CREMATORIAL CITIUMWA, IOWA		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR John M. Welch Leonard Tracy, M.D.		ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 20 1968		25b. REGISTRAR'S SIGNATURE John M. Welch Leonard Tracy, M.D.			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18479

1349

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First JOHN	Middle MURRAY	Last	2a. DATE OF DEATH Month NOVEMBER	Day 27, 1968	Year 1968	2b. HOUR 107 M			
3. SEX M	4 RACE NEGRO	5 DATE OF BIRTH FEB. 4, 1901		6. AGE (In years last birthday) 67	YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) MONTANA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH ST. MARY'S	Md.						
10. CITY OR TOWN OF DEATH VALLEY LEE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABOR		12b. KIND OF BUSINESS OR INDUSTRY						
13a. US. AL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN VALLEY LEE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER VALLEY LEE, MARYLAND						
14. FATHER'S NAME ?	First ?	Middle ?	Last ?	15. MOTHER'S MAIDEN NAME ?	First ?	Middle ?	Last ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 220-10-2629	17. INFORMANT HULINE HAYWARD		Address VALLEY LEE, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hours									
4107 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized anterior sclerosis</i>		10 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201										
19a. DATE OF OPERATION 4201	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State				
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1968</u> to <u>July 27, 1968</u> , that (II) (we) last saw the deceased alive on <u>May 25, 1968</u> , and that in (my) (<u>his</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>P. J. Bean, M.D.</i>	ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Nov 28/68					
22d. PHYSICIAN'S NAME (Type) P. J. BEAN M. D.	22e. ADDRESS GREAT MILLS, MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Nov. 30, 1968	23c. NAME OF CEMETERY OR CREMATORIUM BETHESDA CEMETERY			23d. LOCATION (City or Town) VALLEY LEE, ST. MARY'S, MARYLAND		(County) VALLEY LEE, ST. MARY'S, MARYLAND			(State)
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY	ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DEC 5 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10-16-68

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First Victor	Middle Lyra	Last Myers	20. DATE OF DEATH Month NOVEMBER	Year 1968	2b. HOUR M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH FEBRUARY 1, 1901		6. AGE (in years lost birthday) 67		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0	
7a. BIRTHPLACE (State or foreign country) MISSISSIPPI		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH St. MARY'S			
10. CITY OR TOWN OF DEATH LEONARBTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during past of working life, even if retired) ELECTRICIAN				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY St. MARY'S		13c. CITY OR TOWN HOLLYWOOD,		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 2 Box 266			
14. FATHER'S NAME First WILLIAM		Middle H.		Lost MYERS		15. MOTHER'S MAIDEN NAME First JOSIE		Middle		Lost SCARBOROUGH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 412-01-2373		17. INFORMANT Mrs. SARAH JOHNSON		Address Rt. 2 Box 266 HOLLYWOOD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		472 X		Pneumonitis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 472 X		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Shock - peritonitis, use, collapse + 24 uric											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 11/22, 1961 to 11/28, 1968 , that (I) (we) last saw the deceased alive on 11/28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Leon Berube		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>		22d. MED DIRECTOR <input type="checkbox"/>		22e. STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) LEON BERUBE M. D.		22e. ADDRESS MECHANICSVILLE, MARYLAND									
23a. BURIAL, CREMATION, BONE ASH (Specify) BURIAL		23b. DATE DEC. 1, 1968		23c. NAME OF CEMETERY OR CREMATORIUM NEW HEBRON		23d. LOCATION (City or Town) NEW HEBRON,		(County) MISSISSIPPI		(State)	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARBTOWN, MARYLAND		25a. REC'D. BY REGISTRAR DATE DEC 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

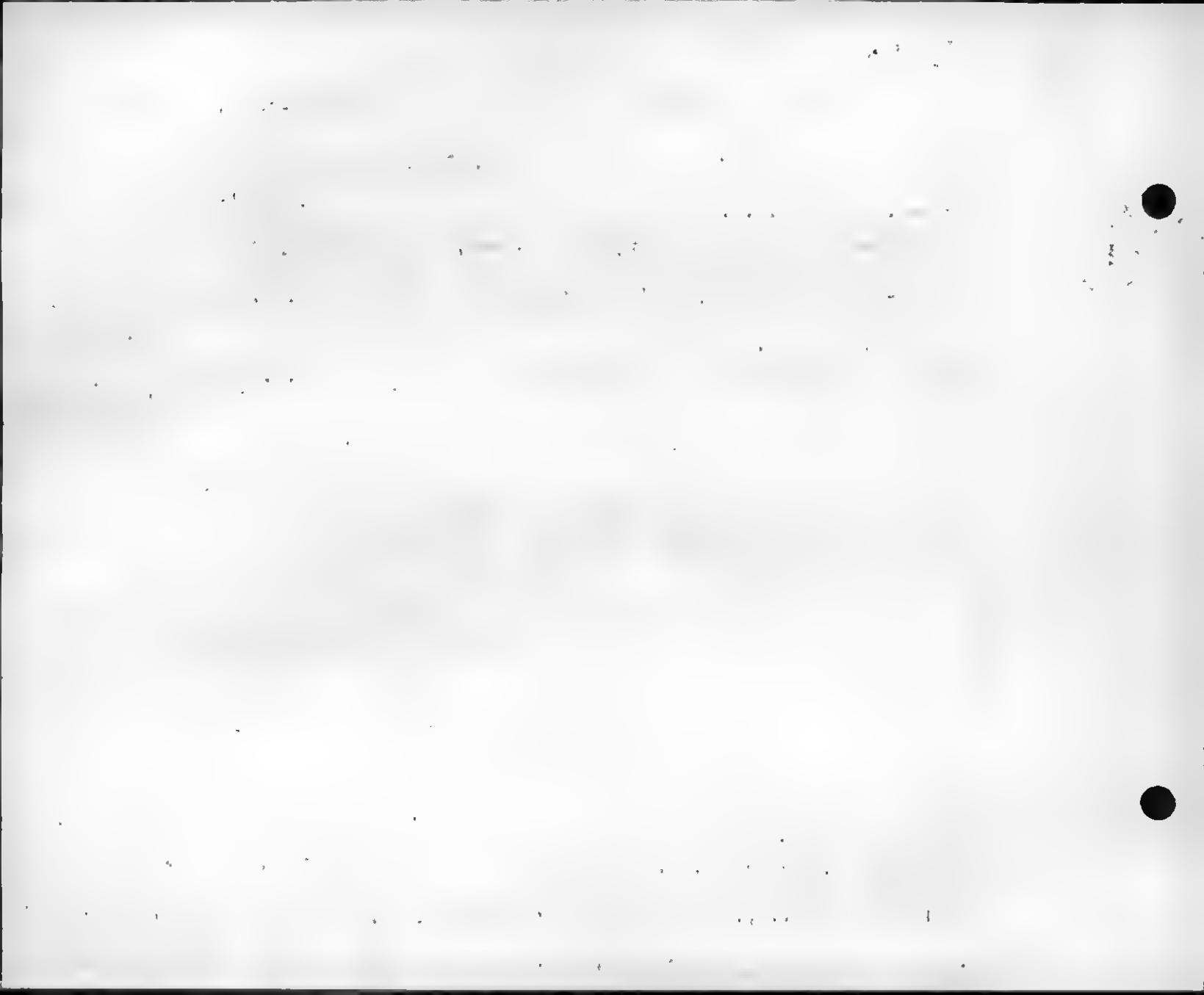


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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First MARY	Middle RUTH	Last PHILLIPS	2a. DATE OF DEATH NOVEMBER 9, 1968			2b. HOUR M
3. SEX FEMALE		4. RACE WHITE			5. DATE OF BIRTH JANUARY 6, 1913		6. AGE (In years last birthday) 55 YRS.		
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED		9. COUNTY OF DEATH ST. MARY'S		
10. CITY OR TOWN OF DEATH LEONARDTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during time of work, if retired) SCHOOL TEACHER			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN LEONARDTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER P. O. BOX 74	
14. FATHER'S NAME O. F. CREE			15. MOTHER'S MIDDLE NAME ROSIE			16. MIDDLE NAME ZIMMERMAN			LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO 213-38-2337			17. INFORMANT XXX GLENN W. PHILLIPS P.O. Box 74 LEONARDTOWN, MARYLAND			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>massive myocardial infarction, CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension, cardiovascular disease</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4.11									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 8, 1968</u> to <u>Nov. 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov. 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>S. Laurel, M.D.</u>		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR		22e. STAFF PHYS.		22f. DATE SIGNED <u>11/10/68</u>	
22d. PHYSICIAN'S NAME (Type) S. LAUREL M. D.		22e. ADDRESS LEONARDTOWN, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Nov. 13, 1968		23c. NAME OF CEMETERY OR CREMATORIAL GREEN COUNTY MEMORIAL PK.		23d. LOCATION (City or Town) WAYNESBURG, GREEN, PENNSYLVANIA		(County) (State)	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR NOV 13 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	
VR A15 (4) 30M REV. 1/68									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

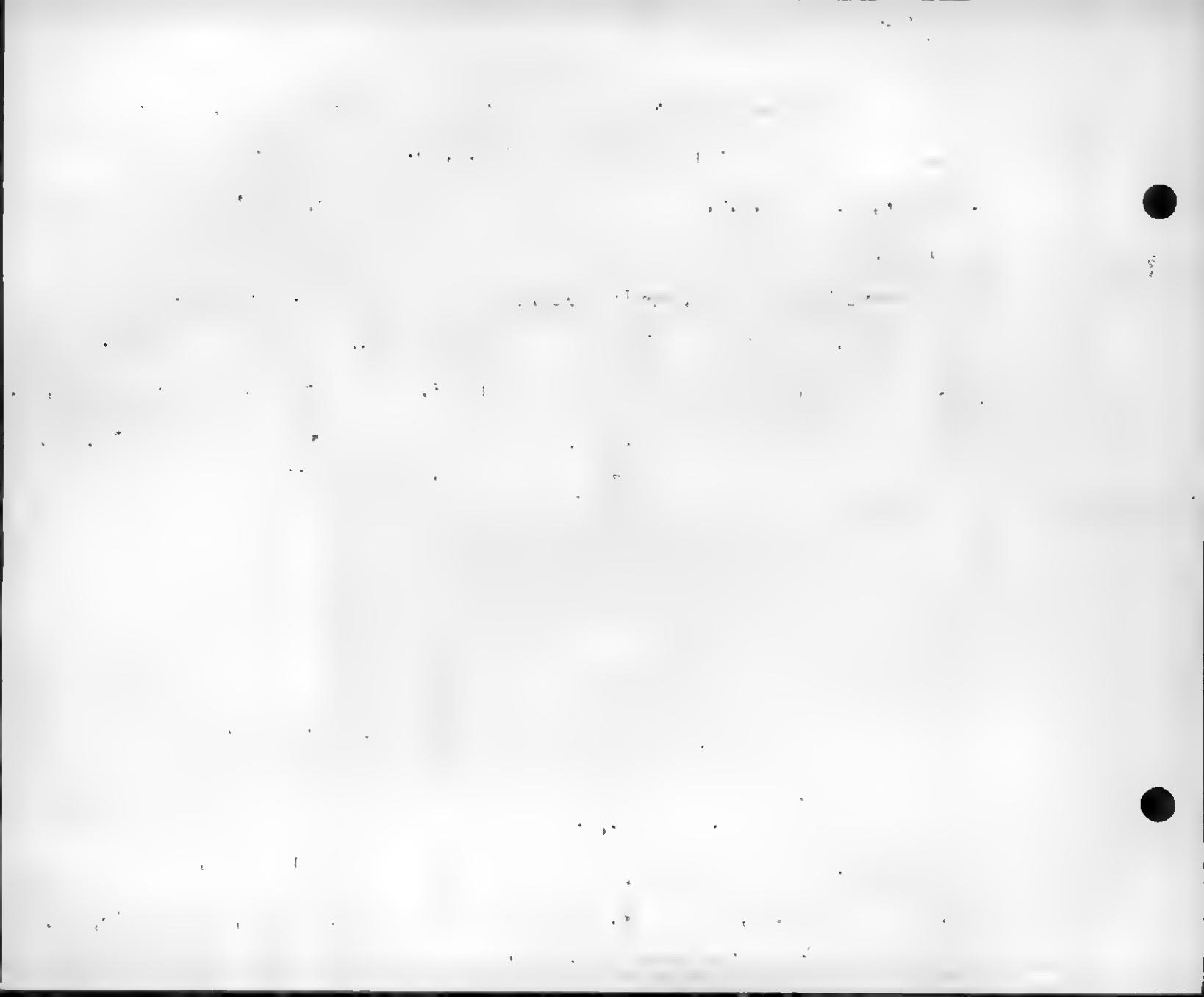
CERTIFICATE OF DEATH

1049..

16482

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1 DECEASED-NAME (Type or print)	First LAWRENCE	Middle YATES	Last RALEY	2a. DATE OF DEATH Month NOVEMBER	Day 24, 1968	2b. HOUR M	
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH AUG. 5, 1889		6. AGE (In years last birthday) 79	7. UNDER 1 YEAR MONTHS YRS.		
8. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH St. MARY'S			
10. CITY OR TOWN OF DEATH HOLLYWOOD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) FARMER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN HOLLYWOOD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RT. 2 Box 122A		
14. FATHER'S NAME First THOMAS	Middle D.	Last RALEY	15. MOTHER'S MAIDEN NAME First MARY	Middle ANN	Last ALMA	YATES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. WW 1	17. INFORMANT WILLIAM E. JOSES	Address RT 2 Box 122A HOLLYWOOD, Md.				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4534 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 1 wk.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. J. ROY GUYTHER	City or Town Mechanicsville	County Maryland	State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 19, 1968 to Nov 24, 1968 , that (I) (we) last saw the deceased alive on Nov 23, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. ROY GUYTHER		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 11/25/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Mechanicsville, Maryland					
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE Nov. 27, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHNS		23d. LOCATION (City or Town) HOLLYWOOD, ST. MARY'S, MD.	(County) St. Mary's Co.	(State) MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY	ADDRESS LEONARDTOWN, MARYLAND		25a. RECD BY REGISTRAR NOV 29 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #23d, Film GL 11/11/68 Items #23a,b,c, Film GL 11/10/68/CERTIFICATE OF DEATH										1040	
1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR			
MARY NINA RIDGELL					NOVEMBER 9, 1968			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
FEMALE		WHITE		OCTOBER 2, 1911		57 yrs.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
MARYLAND		U.S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ST. MARY'S					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
LEONARDTOWN		ST. MARY'S HOSPITAL									
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		Residence before 13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 15 ² YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ST. MARY'S		LOVEVILLE							
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
A. MILLS HEARD					CORA		M.		YATES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <i>Sudden Shock</i>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Syncope</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <i>Cardiac arrhythmia</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (This hospital) attended the deceased from <i>11/10/68</i> to <i>11/10/68</i> , that (I) (not) last saw the deceased alive on <i>11/10/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE											
<i>J. Clarke</i>											
22d. PHYSICIAN'S NAME (Type)		JAMES B. JARBOE M. D.		22e. ADDRESS		GREAT MILLS, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/11/68		23c. NAME OF CEMETERY OR CREMATORIUM Our Lady's Chapel		23d. LOCATION (City or Town) Edgewater Neck, St. Mary's, Md.		(County)		(State)	
24. FUNERAL DIRECTOR		ADDRESS		20650		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. CLARKE MATTINGLEY		LEONARDTOWN, MARYLAND				NOV 13 1968		<i>Charles Judge</i>			



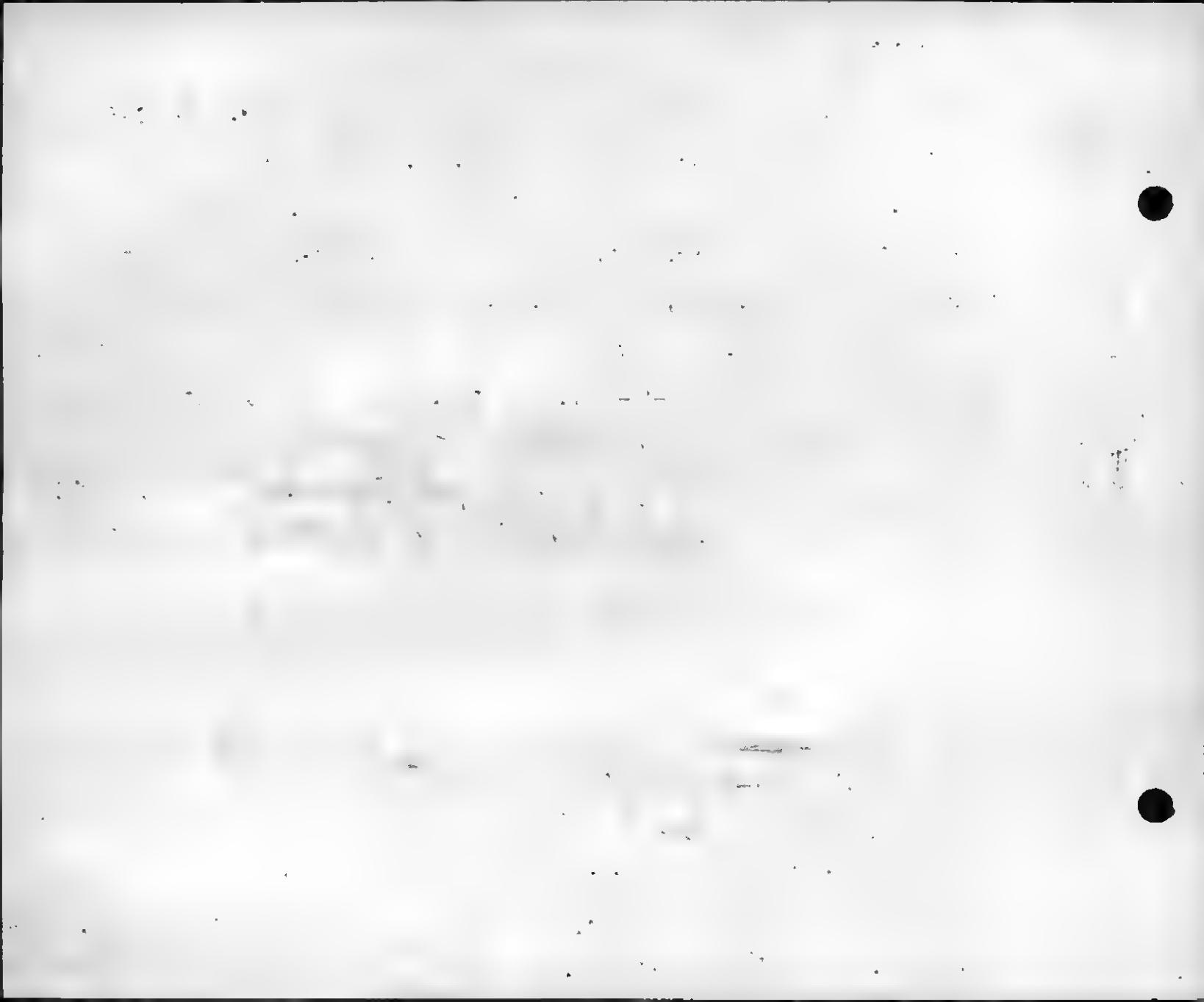
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10) FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours, or as directed.

1. DECEASED NAME (Type or print) JENNIE LENORE SINER			First	Middle	Last	2a DATE OF DEATH Month NOV.	Day 28	Year 1968	2b HOUR		
3. SEX FEMALE		4. RACE WHITE	5. DATE OF BIRTH AUG. 7, 1896			6. AGE (In years last birthday) 72		7. IF UNDER 1 YEAR MONTHS 0		8. F. UNDER 24 HRS HOURS 0	
7a. BIRTHPLACE (State or foreign country) PENN.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. COUNTY OF DEATH ST. MARY, Md.					
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY, S HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res dence before admission) MARYLAND		13b. COUNTY ST. MARY, S	13c. CITY OR TOWN VALLEY LEE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
14. FATHER'S NAME WATSON		First E.	Middle STOUT	Last	15. MOTHER'S MAIDEN NAME ANNIE		Middle		Last HOPKINS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 205-14-0397A		17. INFORMANT HARRY R. SINER		Address SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Subarachnoid hemorrhage massive 2 days (b) hypertension C - V Disease years (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Off											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (Signature) attended the deceased from 1967 to 1968 , that (I) (we) last saw the deceased alive on 11/28/68 , and that in (my) (Signature) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE J. PATRICK BARBOE		DEGREE M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 11/29/68					
22d. PHYSICIAN'S NAME (Type) J. PATRICK BARBOE M.D.		22e. ADDRESS GREAT MILLS Md.									
23a. BURIAL, CREMATION BURIAL (Specify) TRINITY MEMORIAL		23b. DATE 11/30/1968		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS TRINITY MEMORIAL			23d. LOCATION (City or Town) WAIDORF		(County) CHARLES		(State) Md.
24. FUNERAL DIRECTOR JOHN M. WELCH		25. REC'D. BY REGISTRAR DEC 3 1968			25b. REGISTRAR'S SIGNATURE Charles Juge						



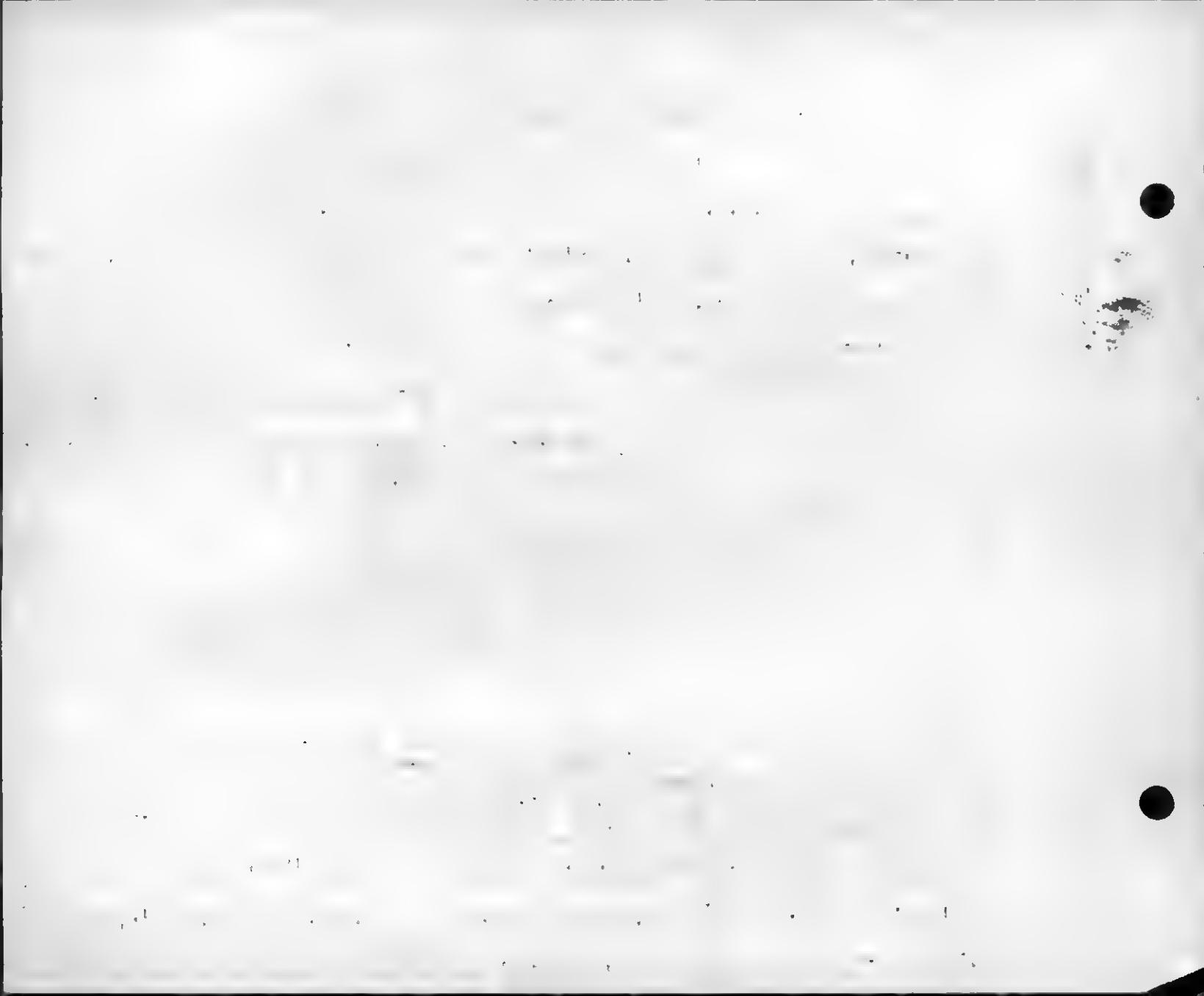
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16485

1649

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with n/72 hours after death.

1. DECEASED NAME (Type or print)	First BERNARD	Middle RUBOLPH	Last SONNEMAN	2a. DATE OF DEATH Month NOVEMBER	Day 17	Year 1968	2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JULY 5, 1898			6. AGE (In years last birthday) 70	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 0
7a. BIRTHPLACE (State or foreign country) U.S.A.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH ST. MARY'S	Md.			
10. CITY OR TOWN OF DEATH LEONARDTOWN,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BALT. GAS, ELECT.			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN DRAYBEN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
14. FATHER'S NAME First HENRY	Middle SONNEMAN	15. MOTHER'S MAIDEN NAME First AUGUSTA	Middle HARTLEB	Address AGNES EDWARDS SONNEMAN DRAYBEN, MARYLAND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown Yes	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Mycardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of Pancreas							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 11/17/68				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. 1117	City or Town 11/17/68	County 11/17/68	State 11/17/68	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/17/68 , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> view the body after death							
22b. SIGNATURE James P. Jarboe		22c. DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22d. DATE SIGNED 11/19/68		
22d. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D.		22e. ADDRESS GREAT MILLS, MARYLAND					
23a. BURIAL, CREMATION, BURIAL (Specify) BURIAL		23b. DATE Nov. 20, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ST. GEORGE EPISCOPAL	23d. LOCATION (City or Town) (County) (State) VALLEY LEE, ST. MARY'S, MARYLAND			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR NOV. 22 1968	25b. REGISTRAR'S SIGNATURE Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any day is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16486 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

165111

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH ESTI- MATED	Month	Day	Year	2b HOUR
DENNIS (HAWK) THOMAS						<input checked="" type="checkbox"/>	11	29	1968	8:pm
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER MONTHS	YEAR	8 IF UNDER 24 HRS HOURS	MIN			
Male	Colored	1920 FEB. 1, 1946	48 ?	YRS						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD Month November 29 Year 1968 8 pm		
MARYLAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		St. Mary				
10. CITY OR TOWN OF DEATH Chaptico			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Lathum's Store			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.			13c. CITY OR TOWN St. Mary			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Chaptico, Md.	
14. FATHER'S NAME JOHN A. THOMAS			15. MOTHER'S MAIDEN NAME DOLLY THOMAS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT JOHN D. COUNTISS (SON) OAKLEY, MARYLAND JOHN A. THOMAS // CHAPTICO, MARYLAND			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Shotgun wound of the abdomen							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO, OR AS A CONSEQUENCE OF (b)							
			DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOURS 7:05 P.M. 11 29 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) Shot by owner of above store				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Store			21f. LOCATION Street or R.F.D. No Lathum's Store			City or Town St. Mary	County Chaptico Md.
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Edward F. Wilson, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 11/30/68	
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE DEC. 3, 1968		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS SACRED HEART			23d. LOCATION (City or Town) BUSHWOOD, ST. MARY'S, MARYLAND		(County)	(State)
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND			25a. RECD BY REGISTRAR DEC 5 1968		25b. REGISTRAR'S SIGNATURE K. Cleary, Judge			



1
FOR STATE
HEALTH DEPT.

16487
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office alone, with form PM3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16501

1. DECEASED NAME (Type or Print)		First GARNETT	Middle	Last WATTS	2a. DATE KNOWN OF DEATH ESTIMATED MATED	Month Nov. 4,	Day 19 68	Year M	2b. HOUR		
3. SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH FEB. 23, 1900	6. AGE IN YEARS 68 LAST BIRTHDAY	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Nov. Day 4, Year 19 68				2d. HOUR M	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED X NEVER MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH ST. MARY'S								
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN ST. MARY'S DRAYDEN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER						
14. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT MATTIE WATTS DRAYDEN, MARYLAND				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8239		Exsanguination				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c),		DUE TO, OR AS A CONSEQUENCE OF Traumatic amputation left arm									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 912.1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:00 PM Noon 11-4-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Colliding caught in tractor Power takeoff							
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Farm		21f. LOCATION Street or R.F.D. No. Drayden		City or Town		County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						22b. DATE SIGNED 11-4-68					
ACTUAL SIGNATURE <i>Alfred Boyd</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 11-4-68					
EXAMINER'S NAME (Type) WILLIAM D. BOYD M. D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 11-4-68					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 8, 1968		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bethesda Ch. Cem. Martell Adams Aquasco, Md.		23d. LOCATION (City or Town) Valley Lee St. Mary's Md.		(County) St. Mary's Md.		(State)	
24. FUNERAL DIRECTOR Martell Adams Aquasco, Md.						25a. REGD BY REGISTRAR NOV 12 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16488

16502

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First WILLIAM	Middle OLIVER	Last WISE	2a. DATE OF DEATH Month NOVEMBER	Day 15	Year 1968	2b. HOUR M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH APRIL 29, 1887			6. AGE (in years (last birthday) 81	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. MONTHS MONTHS	IF UNDER 24 HRS. DAYS DAYS	2b. HOUR HOURS HOURS	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ST. MARY'S	Md.				
10. CITY OR TOWN OF DEATH LEONARDTOWN,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CABINET MAKER			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN HERMANYVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 1 BOX 132					
14. FATHER'S NAME First ROBERT	Middle McKINSLY	Last WISE	15. MOTHER'S MAIDEN NAME First LYDIA			Middle BISCOE	Address MARY E. WISE RT. 1 Box 132 LEXINGTON PARK, MD.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes						16b. SOCIAL SECURITY NO. 217-07-2376	17. INFORMANT Mrs. MARY E. WISE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						<i>Circulatory Collapse</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs.
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						<i>Myocardial Failure</i>				<i>day</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Diabetes Mellitus						<i>Coronary Artery Disease</i>				<i>yes</i>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (the hospital) attended the deceased from 19/68 to 11/15/68 , that (I) (we) last saw the deceased alive on 19/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>James P. Jarboe M.D.</i>		22c. DEGREE ATTENDING PHYS.			22d. MED. DIRECTOR <input checked="" type="checkbox"/>		22e. STAFF PHYS. <input type="checkbox"/>			22f. DATE SIGNED 10/17/68
22d. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D.		22e. ADDRESS GREAT MILLS, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Nov. 17, 1968		23c. NAME OF CEMETERY OR CREMATORIAL ST. ANDREWS			23d. LOCATION (City or Town) (County) (State) LEONARDTOWN, ST. MARY'S, MARYLAND			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND			25a. REC'D BY REGISTRAR DATE NOV 19 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

